

**REPORT
TO
THE HOUSE OF REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEE
ON HEALTH AND HUMAN SERVICES**

**SENATE APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN
SERVICES**

**JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES**

AND

FISCAL RESEARCH DIVISION

ON

THE COMPREHENSIVE TREATMENT SERVICES PROGRAM (CTSP)

**Session Law 2005-276
Senate Bill 622, Section 10.25**

September 1, 2007

**NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND
SUBSTANCE ABUSE SERVICES**

EXECUTIVE SUMMARY

The General Assembly of North Carolina, in its 2001 Session, passed legislation to establish the Comprehensive Treatment Services Program (CTSP) for children (children/adolescents) at risk for institutionalization or other out-of-home placements. The Department of Health and Human Services (DHHS) was charged with the implementation of the Program in collaboration with the Division of Social Services (DSS), Department of Juvenile Justice and Delinquency Prevention (DJJDP), the Department of Public Instruction (DPI), the Administrative Office of the Courts (AOC) and other relevant State agencies to provide appropriate and medically necessary residential and non-residential treatment alternatives for the target population.

The infrastructure for Program implementation is in place and progress continues with expansion and quality improvement.

- The mechanism for funding community-based alternatives and eligibility criteria was expanded in 2004 legislation.
- Collaboratives formed at the State and Local community levels continue to build capacity through policy and guideline development.
- Local Management Entities (LMEs) continue to promote Consumer Family Advisory Councils (CFACs) and better support consumers and families in full participation and leadership.
- Families are represented in the State Collaborative and Local Community Collaboratives, which continue to formalize their structures.
- An integrated Memorandum of Agreement (MOA) exists between all relevant agencies at the State and local levels.
- The array of medically necessary non-residential and residential services has expanded through the development of new service definitions, approved in December 2005.
- Expansion continues with evidenced based, best and emerging best practice community based services with new definitions implemented March 20, 2006.
- The Program served 12,056 children/adolescents in state fiscal year (SFY) 2005-2006.

INTRODUCTION AND HISTORICAL CONTEXT

It has long been recognized in the public service field that children/adolescents with complex mental health challenges can be kept out of institutional facilities through a coordinated and community-based system of services. As early as 1969, the Joint Commission on Mental Health of Children called for a broad array of services for the prevention and treatment of mental illness after a five-year study that started in 1964. The President's Commission on Mental Health urged a coordination of services in 1978. But not until the Willie M. Program (Soler and Warboys, 1990) was the concept "system of services" translated into practice on a massive scale. The Willie M. lawsuit guaranteed that each child/adolescent in the class had the right to individualized treatment based on needs, rather than available services, and to have these services provided in the least restrictive setting possible. The Willie M. program ended in 1998, when the lawsuit was dismissed and the State was found to be in compliance with the stipulations of the settlement (North Carolina Department of Health and Human Services and North Carolina Department of Public Instruction, 1999).

The termination of the Willie M. lawsuit in 1998 provided the opportunity to extend the delivery of a continuum of services to all children/adolescents with serious mental, emotional, and behavioral difficulties in all counties throughout the State. In its 2001 session, the General Assembly of North Carolina passed legislation to establish the Comprehensive Treatment Services Program (CTSP) for children/adolescents at risk for institutionalization or other out-of-home placements, marking the beginning of a statewide implementation of System of Care (SOC) practices and principles.

The NC Collaborative for Children, Youth and Families (www.nccollaborative.org) was formed in 2001 to promote a coalition among agencies cited by the NC General Assembly in the legislation that established the Program. The Child Mental Health portion of the State Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) Plan is explicit in its support of SOC. The goal under the plan is to provide a "system of quality care, which includes accessible, culturally sensitive, individualized mental health treatment, intervention and prevention services delivered in the home and community in the least restrictive and most consistent manner possible." The emphasis on System of Care practices and principle, including interagency coordination and collaboration in partnership with families and children/adolescents as a practice platform embraced by mental health reform has been the catalyst for developing an inter-divisional and inter-departmental approach to serving children in communities, significantly shaped by the families served. Transformation of the MH/DD/SAS system embraces other essential components of a comprehensive SOC which are also emphasized in this special provision.

This report summarizes the progress achieved in implementation of the CTSP pursuant to Section 10.25 (a) & (m) of Session Law 2005-276, Senate Bill 622.

PROGRESS IN MEETING PROGRAM INDICATORS

SECTION 10.25. (a)

The Department of Health and Human Services shall continue the Comprehensive Treatment Services Program for children at risk for institutionalization or other out-of-home placement. The Program shall be implemented by the Department in consultation with the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, and other appropriate State agencies. The purpose of the Program is to provide appropriate and medically necessary residential and nonresidential treatment alternatives for children(children/adolescents) at risk of institutionalization or other out-of-home placement. Program funds shall be targeted for non-Medicaid eligible children. Program funds may also be used to expand a SOC approach for services to children/adolescents and their families statewide. The Program shall include the following:

- (1) *Behavioral Health Screenings for all children (children/adolescents) at risk of institutionalization or other out-of-home placement.*
 - Behavioral health screenings are performed for all children/adolescents in the target population using a standardized Screening, Triage and Referral protocol by Local Management Entities (LMEs) and community providers serving children/adolescents with severe emotional disorders.
 - In 2005, an initiative of the Division of Social Services (DSS) and DMH/DD/SAS with a cross-section of other community agencies, community providers and academic researchers was formed to explore and develop common rules, definitions, protocols and guidelines based on evidenced-based, best and emerging best practices. A focus of the initiative was to promote the continuity of care, services and supports to children/adolescents needing foster care or in the foster care system. Ongoing work continues, as both divisions work to improve access, initial and comprehensive child/adolescent and family assessments, for risk, safety and treatment. Efforts continue in aligning policy and practice with screening, assessment instruments and protocols across child/adolescent serving agencies.

- Eligibility determination for CTSP services is a joint process with the referring community agency, the parent/caregiver, and the LME completing the assessment process as a team.
 - Health Check, which is a component of Early, Periodic, Screening, Diagnosis and Treatment (EPSDT), in a joint collaborative agreement with the Division of Medical Assistance (DMA) and Department of Public Health (DPH), is a statewide comprehensive system for early and periodic screening of children/adolescents from birth to 21 years old who are Medicaid eligible.
 - Health Choice (State Children's Health Insurance Program in NC) continues to offer services and supports for children/adolescents with behavioral health care needs who are uninsured in coordination with DMH/DD/SAS, DMA and DPH.
- (2) *Appropriate and medically necessary residential and non-residential services for deaf children* (children/adolescents who are deaf, hard of hearing (HOH), deaf-blind).
- The State has eligibility protocols to better identify and serve children/adolescents who are deaf, HOH or deaf-blind for specialized mental health, developmental disabilities and substance abuse services.
 - Specialized staff fluent in American Sign Language (ASL) provide direct services to children/ adolescents qualifying for CTSP. Staff work closely with public school systems, the two state schools for the deaf, advocacy groups, community collaboratives, Area Authorities and County Programs, consumer and provider organizations, and family members to ensure that SOC principles are utilized and specialized services are coordinated. When staff are unavailable to provide direct services, the State assists local programs with making service language accessible through its sign language program.
 - In SFY 2006, the LMEs used CTSP funding to provide language accessible mental health services to children/adolescents who are deaf and meet CTSP guidelines. The funding was to purchase interpreting services that enabled eligible children/adolescents who are deaf to access specialized therapy and evaluation services.
 - The total Integrated Payment and Reporting System (IPRS) payment for SFY 2005-2006 for 103 children/adolescents who are deaf/HOH was \$75,190.

- (3) *Appropriate and medically necessary residential and non-residential treatment service, including placements for sexually aggressive youth (children/adolescents with challenging sexual behaviors).*
- Children/adolescents with challenging sexual behaviors continue to be identified and included as a part of the target population eligible for CTSP funding.
 - Statewide data base of independent practitioners was developed by DMH/DD/SAS to provide resources for evaluating and treating children with challenging sexual behaviors, and adolescents adjudicated or at risk of adjudication for sexual behaviors.
 - Appropriate and medically necessary residential and non-residential treatment services for children/adolescents are being addressed in the service definitions, including Diagnostic Assessment, Community Support, Intensive-In-Home and Multi-Systemic Therapy (MST); Substance Abuse Adolescent Intensive Outpatient Treatment that became effective in March 2006.
 - Division research is being conducted on evidenced based, best and emerging best practices for working with children/adolescents with challenging sexual behaviors within a SOC approach.
 - DMH/DD/SAS partnered with DSS, the Center for Child and Family Health-NC, Duke National Center for Child Traumatic Stress and other organizations to support a three year Child Treatment Program – Pilot initiated by the University of North Carolina at Chapel Hill and the Center for Child and Family Health-NC to provide evidenced-based treatment for child sexual abuse in northeastern North Carolina.
 - In an on-going effort to keep providers informed of evolving best practice treatments/ interventions across a spectrum of child/adolescent sexual behavior problems, DMH/DD/SAS provides training opportunities through the Annual Statewide Community Support and Targeted Case Management Conference.
- (4) *Appropriate and medically necessary residential and non-residential treatment services, including placements for youth (children/adolescents) needing substance abuse (substance-related*

use) *treatment services and children(children/adolescents) with serious emotional disturbances (SED).*

- Legislation in SFY 2004 provided for policy and guidelines to be put in place for SFY 2005 to provide more flexibility in the use of funds. This provided additional services and supports to benefit children/adolescents with substance-related use disorders who are at risk of out-of-home placements.
- Residential and non-residential services and supports for children/adolescents with substance-related use disorders are being addressed through a revision of the rules and service definitions to better reflect evidenced based, best and emerging best practices through a SOC approach.
- Substance Abuse Treatment Block Grant funds are dedicated to the development of community-based treatment options for children/adolescents with substance-related use issues.
- On July 20, 2005, an award from the Substance Abuse and Mental Health Services Administration was issued for The Adolescent Treatment Coordination Grant for the period of August 1, 2005 – July 31, 2008. The project will develop a sustainable infrastructure for substance-related use treatment coordination that will strengthen the capacity of the DMH/DD/SAS to serve adolescents in need of substance-related use disorders and their families. This project builds on an existing collaborative effort between parents and adolescents, DMH/DD/SAS, DJJDP and other child/adolescent serving public and private agencies as part of the operationalization of the CTSP and the Managing Access for Juvenile Offender Resources and Services (MAJORS) Program.

(5) Multidisciplinary case management services, as needed.

- Child and Family Teams (CFT) are the vehicles for person-centered planning (PCP). The primary provider serves as the “clinical home” and is responsible for convening the CFT and facilitating the family-centered process of identifying strengths and needs, developing goals, and an action plan. The intent of the person (child/adolescent and family) centered planning is to provide continuity of care to

ensure that desired outcomes are achieved. Crisis and transition planning are elements of this planning process.

- The new and enhanced service definitions implemented in SFY 2006 integrate case management functions with therapeutic interventions increasing the availability and coverage of evidenced-based, best and emerging best practice services and supports.

(6) *A system of utilization review specific to the nature and design of the Program.*

- CFTs identify and assess the needs of each child/adolescent, in equal partnership with the family to ensure comprehensive care.
- DHHS through DMA established a single statewide vendor, who provides Utilization Review (UR) for Medicaid services. ValueOptions has incorporated the SOC essential components into their UR protocols. Further development of a system of UR is underway through the State Plan transformation efforts, and the person centered planning process, to better ensure the right intensity of services needed throughout the implementation of the person centered plan..

(7) *Mechanisms to ensure that children(children/adolescents) are not placed in department of social services custody for the purpose of obtaining mental health residential treatment services.*

- The DSS-DMH/DD/SAS Memorandum of Agreement (MOA) developed in SFY 2002-2003, makes clear that unnecessary placements with the DSS are not allowed.
- The NC State Collaborative for Children, Youth and Families has recommended that the Social Services Block Grant Plan include an allocation to serve as a flexible source of funds with specific requirements to divert unnecessary DSS custody.
- In keeping with the principles of SOC and the outcomes identified and implemented in the PCP, children/adolescents receive services in the least restrictive and most community-based setting possible. In no instance, should families have to give up custody of their children/adolescents in order to obtain appropriate services.

(8) *Mechanisms to maximize current State and local funds and to expand use of Medicaid funds to accomplish the intent of this Program.*

- In a memorandum from the DMH/DD/SAS on December 3, 2004, Area Authority and County Program directors were notified of additional CTSP Funding Guidelines for UCR and Non-UCR funds effective December 1, 2004. The changes allow for the expansion in 2005 of the use of CTSP funds for additional children/adolescents who are *at-risk* for out of home placement, and for additional supports and services. The guidelines were to increase flexibility in the use of UCR and Non-UCR CTSP funding to support and sustain SOC principles as a best practice organizing framework for children/adolescents with mental health and/or substance use disorders.
- The CTSP guidelines also support and encourage the use of funds for training and technical assistance to facilitate system change, increase community capacity to establish evidenced based, best and emerging best practices, prevention and early intervention services and support child/adolescent and family participation in our system.
- Research in evidenced based, best and emerging best practices indicates that in-home services such as Intensive-In-Home and MST promote family preservation and have positive outcomes for children with SED and their families. As a response to this, a Request for Applications (RFA) to Area Authorities and County Programs was issued by the Division in SFY 2005, for the distribution of \$1.8 million in MH/DD/SAS Trust Funds. Funds were allocated as start-up funding to increase child/adolescent mental health community-based services capacity. Funding was specifically identified for the establishment of Intensive In-Home services, with respite and crisis components, or to enhance existing Intensive In-Home services in the communities.
- CTSP funds served 12,055 children/adolescents in SFY 2005-2006, compared to the 13,201, served in SFY 2004-2005.
- According to the MH/DD/SA Budget and Finance Office for children/adolescents served as CTSP eligible, the majority of funds, \$278,410,084 were paid through Medicaid. The funding expended through the Integrated

Payment and Reporting System (IPRS) for UCR expenditures, \$11,796,385, and Non-UCR expenditures, \$4,431,225, totaled \$16,227,610 for SFY 2006-2007.

- A comparison of UCR and Non-UCR paid claims for SFY 2004-2005, SFY 2005-2006 and SFY 2006-2007:

	<u>SFY 2004-2005</u>	<u>SFY 2005-2006</u>	<u>SFY 2006-2007*</u>
UCR	\$25,089,268	\$22,495,115	\$11,796,385
Non-UCR	\$2,720,957	\$2,037,887	\$4,431,225

*The decrease in the use of CTSP funds from SFY 2004 -05 to SFY 2006 - 07 reflects the increase in Medicaid eligibility children/ adolescents.

* The numbers do not include data for both Piedmont and Smoky Mountain as a result of their pilot demonstration projects.

(9) *Other appropriate components to accomplish the Program's purpose.*

- New and enhanced service definitions went into effect March 20, 2006, providing services and supports and a case management model of delivery, within the context of each service definition. This represented a time period of slightly more than 3 months, from March 20, 2006 through June 30, 2006.

Service Definition*	Medicaid Funds		IPRS Funds	
	Expended	Persons	Expended	Persons
** Community Support	\$85,609,112	18,019	\$1,728,086	1,156
Intensive In-Home	\$856,228	259	\$45,220	21
Multi-Systemic Therapy	\$225,701	60	\$41,430	17
Totals				
	\$86,691,041	18,338	\$1,814,736	1,194

* **Service Definitions** provide a description of the service to be provided in addition to the components required to provide the service, Medicaid and IPRS codes are assigned for billing purposes.

**Community Support, Intensive In-Home and Multi-Systemic Therapy definitions can be found on the Division's website:
ncdhhs.gov/mhddsas/servicedefinitions/index.htm

(10) *The Secretary of the Department of Health and Human Services may enter into contracts with residential service providers.*

- Contracting with residential providers has been successfully managed at the LME level; however, if necessary the Secretary of DHHS may enter into contracts with providers.
- (11) *A system of identifying and tracking children (children/adolescents) placed outside of the family unit in group homes, therapeutic foster care home settings, and other out-of-home placements.*
- All LMEs are billing IPRS except for Smoky Mountain Center and Piedmont Behavioral Health Care who are engaged in pilot demonstration projects which include their CTSP funding.

SECTION 10.25 (b)

In order to ensure that children(children/adolescents) at risk for institutionalization or other out-of-home placement are appropriately served by the mental health, developmental disabilities, and substance abuse services system, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall do the following with respect to services provided to these children:

- (1) *Provide only those treatment services that are medically necessary.*
- Service definitions identify medically necessary Eligibility Criteria, Continued Stay Criteria and Discharge Criteria. These criteria provide guidance for the decision-making process in ensuring the needs of children/adolescents are clearly identified, addressed and reassessed for services, and supports to meet treatment needs and outcomes.
 - The DHHS, through leadership of DMH/DD/SAS, is charged with the implementation of the Program in collaboration with the DSS, DJJDP, DPI, and other relevant State agencies to provide appropriate residential and non-residential treatment alternatives for the CTSP eligible population.
- (2) *Implement utilization review of services provided.*

- ValueOptions is the statewide authorizing agent in determining medical necessity for treatment services for Medicaid eligible and Health Choice children/adolescents.
 - The LMEs are the authorizing agents for state funded services for which the Division of MH/DD/SAS is authorized through appropriations and other federal or foundation funding.
- (3) *Adopt the following guiding principles for provision of services:*
- (a) *Service delivery system must be outcome-oriented and evaluation-based.*
- The essential elements of SOC System of Care practice requires adherence to the principles referenced in the 2004-2005 legislation. CTSP continues to be implemented through a statewide SOC approach, i.e., outcome-oriented, evaluation-based.
 - Outcomes data is being collected for children/adolescents through the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS).
- (b) *Services should be delivered as close as possible to the child's home.*
- The SOC principle of community-based services is promoted throughout the system. Child and Family Teams work to ensure that services for a child/adolescent are as close to home as possible. Local Collaboratives also work to increase community capacity so that services needed in their area are available.
- (c) *Services selected should be those that are most efficient in terms of cost and effectiveness.*
- The integration of all involved parties in one comprehensive CFT reduces duplication of services and fragmentation of delivery. Services delivered are those agreed upon by the CFT and approved through the review process.

- Evidence based, best and emerging best practices, including the SOC approach continue to be identified and developed for implementation through service definitions and rule revision to ensure efficient and effective services and supports.
 - The DMH/DD/SAS is continuously aware of research and evaluation on evidenced based, best and emerging best practices for children/adolescents. Since the inception of the North Carolina Practice Improvement Collaborative (NCPIC) in 2005, the DMH/DD/SAS receives recommendations regarding effective practices which have been carefully reviewed by clinical experts. In SFY 2006-07, the NCPIC reviewed Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for implementation in NC.
- (d) *Services should not be provided solely for the convenience of the provider or the client.*
- Services are determined through the process of the CFT planning. Efforts to identify and address positive life outcomes and medically necessary needs of the child/adolescent are a part of this planning. The CFTs are often lead by the family, often and usually include cross agency service providers so there is full community representation and collaboration consistent with the SOC approach.
- (e) *Families and consumers (children/adolescents) are involved in decision making throughout treatment planning and delivery.*
- A core value of a SOC approach is the active involvement of families at all levels of service, program and system activities.
 - A parent of a child/adolescent with SED co-chairs the NC Collaborative for Children, Youth and Families, and all Local Community Collaboratives support and actively encourage full participation of family members to represent the interests of local families.
 - The Training Work Group of the NC Collaborative has recently completed an interagency Child and Family Team training curriculum, written from the family's perspective.

The training is delivered by co-trainers, one agency person and one family member. It is currently being delivered to child-serving staff and family members in communities across the state.

- Recent allocation of CTSP funding includes a percentage of funds for which a plan can be submitted to the DMH/DD/SAS by the community collaborative through the LME to support the involvement of families in SOC. Family members actively participate in the State Collaborative and in Local Community Collaboratives.
- A high priority and key component of the Mental Health Planning Council is child/adolescent and family involvement to ensure effective planning for services and supports for children/adolescents and their families.
- In addition to working through the State and Local Collaboratives, the DMH/DD/SAS works closely with organizations and advocacy groups who have a primary interest in promoting health, social and emotional development of children/adolescents to increase family member involvement locally and on the state level. These groups include the Mental Health Planning Council, the Young Families Network of the National Alliance for Mental Illness, the Mental Health Association in NC, Families United and Powerful Youth, the NC Family Support Network, Action for Children, the Covenant for Children, Coalition 2010, NC Foster Family and Parent Association, NC Partnership for Children, Prevent Child Abuse in NC, Parent Advisory Council to DPH, Exceptional Children's Assistance Center, the ARC of NC, NC Autism Society, the NC Pediatric Society and parent support groups in local communities.
- Collaboratives, the planning structures with representatives from families and all child-serving agencies, community stakeholders, and families are being supported and maintained at the State and local levels.
- CTSP legislation requires collaboratives to include family members and consumers who have children/adolescents currently in the system or who have been in the system.

- (4) *Implement all of the following cost reduction strategies:*
- (a) *Preauthorization of all services except emergency services.*
- CFTs, through the process of the PCP develop medically necessary supports and services for positive outcomes.
 - Each service definition incorporates the Initial, Continuation and Discharge Criteria which provide the protocol for guiding decision-making in providing the right intensity of service at the appropriate time.
- (b) *Levels of care to assist in the development of treatment plans.*
- Services and training initiatives since 2006, support LMEs in providing UR for all state-funded services, including those funded by CTSP.
- (c) *Clinically appropriate services.*
- The Eligibility Criteria and Continuing Authorization Criteria describe the clinical indicators that should exist to consider the authorization of a particular service and facilitate care management.

SECTION 10.25 (c)

The Department shall collaborate with other affected State agencies such as the Department of Juvenile Justice and Delinquency Prevention, Department of Public Instruction, the Administrative Office of the Courts, and with local department of social services, area mental health programs, and local education agencies to eliminate cost shifting and facilitate cost-sharing among these governmental agencies with respect to the treatment and placement services.

- The NC State Collaborative for Children, Youth and Families' list of accomplishments is extensive. This group has provided valuable input into the NC-TOPPS, and supported the pursuit of grant and foundation funds at the state, regional and local levels. The Collaborative is represented by DHHS, DJJDP, DPI and respective divisions and staff from these state agencies, NC Interagency Collaborating Council, for children birth-5 years with disabilities and their families, advocates, families, providers, community collaborative partners, and the faith-based community.

- The primary focus of the CTSP legislation is the provision of services and system collaboration with a focus on children with SED who are served by multiple agencies, and are in, or at risk for, out of home placement. Emphasis is placed on family involvement and agency collaboration at local, regional and state levels and promoting alternatives to residential treatment that are outcomes driven.
- Through the collaboration of state agencies, diversions have occurred from youth development centers, state psychiatric institutions, DSS custody and school suspensions and expulsions.
- Initiatives like the Managing Access for Juvenile Offender Resources and Services (MAJORS) program provides evaluation, diversion, training and technical assistance to substance-related use and SED juvenile justice involved children/adolescents.
- A cooperative agreement between DPI and the DHHS facilitates compliance with the regulations set forth under Part B (3-20) of the Individuals with Disabilities Education Act (IDEA as amended) as they pertain to children with disabilities served by both agencies. This agreement focuses on providing educational services for students with disabilities that are in DHHS residential facilities. The DHHS serves as a Local Education Agency (LEA) with education.
- SFY 2006, the Governor's CFST Initiative provided funds to be allocated for CFST and LME Care Coordinators. This provided 18 positions in 15 LMEs. Priority was given to schools designated in the Governor's Child and Family Support Team Initiative. The Care Coordinator serves as the primary contact for the schools in the catchment area for children/adolescents and families identified as having behavioral health issues. Other activities include training for school personnel; coordinating an in-depth assessment when routine or specialized screenings identify mental health, developmental disabilities or substance abuse issues; and facilitating.
- The NC State Collaborative for Children, Youth and Families continues to meet monthly with the goal of improving outcomes for children/adolescents and families, especially but not limited to those with MH/DD/SA needs, through a SOC framework for community based services and supports.
- In SFY 2006, the legislature made an appropriation to the Division of MH/DD/SAS which in turn allocated funding to support a

System of Care Coordinator in each Local Management Entity whose tasks include staffing local collaboratives, ensuring family involvement, providing technical assistance to the provider community on the Child and Family Team model, and quality management.

SECTION 10.25. (d)

The Department shall not allocate funds appropriated for Program services until a Memorandum of Agreement (MOA) has been executed between the Department of Health and Human Services, the Department of Public Instruction, and other affected State agencies.

- The NC State Collaborative for Children, Youth and Families has been successful in developing one integrated MOA between all relevant State agencies, including DHHS, DPI, AOC and DSS, Area Authorities and County Programs, and LEAs. The MOA delineates responsibilities of local child-serving agencies.
- The MOA was reviewed and updated last year and is in effect and a meeting of the relevant agencies included a review of commitments and necessary adjustments reflecting changing mandates and functions among and within the individual agencies.
- The State level CTSP MOA between these agencies was updated in SFY 2006.

SECTION 10.25 (e)

Notwithstanding any other provision of law to the contrary, services under the Comprehensive Treatment Services Program, are not an entitlement for non-Medicaid eligible children served by the Program.

- All training and correspondence relevant to this topic emphasizes that services are not an entitlement.

SECTION 10.25. (f)

Of the funds appropriated in this act for the Comprehensive Treatment Services Program, the Department of Health and Human Services shall establish a reserve of three percent (3%) to ensure availability of these funds to address specialized needs for children with unique or highly complex problems.

- The North Carolina DMH/DD/SAS issued the December 3, 2004, memorandum, “Expanded CTSP Funding Guidelines for Area Authority/County Programs for UCR and Non-UCR Funds”.
- The Division approved Non-UCR CTSP funding reallocations for eighteen LMEs. LMEs approved for Non-UCR expenditures are required to submit year-end activity reports by August 31, 2007. The Non-UCR funding requests that were approved in SFY 2006-2007, totaled \$4,431,225. Federal funding allocated through the Mental Block Grant totaled \$1,902,003 for SFY 2006-2007.
- In the August 31, 2004, DMH/DD/SAS Memorandum to Area Program Directors, LMEs can move up to 10% of their budgets to Non-UCR. Also, 50% of CTSP unused funds are rebudgeted for the following year; the remaining balance is reverted.

SECTION 10.25 (g)

The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, Department of Public Instruction, and other relevant agencies, shall report on the following Program information:

- (1) ***The number and other demographic information of children served.***
 - From July 2005 through June 2006, a total of 12,055 children and adolescents with SED were actively served. Of those children and adolescents for whom race was reported, 48% were Caucasian, 50% were Black, with 2% being Native American and/or Asian. For ethnicity of children/adolescents served, more than 16% reported being Latino/Hispanic.
- (2) ***The amount and source of funds expended to implement the Program.***
 - The amount of \$252,565,258 was expended to serve children/adolescents in the program with the bulk expended through Medicaid funding paid July 2005-July 2006. More than 30% of eligible children/adolescents were deemed Medicaid eligible. This is a result of the special provision’s intent to improve access to services for those children/adolescents whose first payer was Medicaid.
 - The total expended through IPRS for UCR and Non-UCR earnings was \$16, 227,610, based on claims paid July 2006-June 2007. As a result of the requirement to remove barriers for accessing this state funding for eligible children/adolescents who are not eligible for

Medicaid, increased utilization of funds resulted through Non-UCR, which offered family supports and alternatives to residential treatment for children/adolescents in their community.

(3) *Information regarding the number of children screened, specific placement of children, including the placement of children in programs or facilities outside the child's home county, and treatment needs of children served.*

- All children/adolescents referred for enrollment into the Program are screened to determine whether they meet eligibility criteria and are eventually entered into the IPRS database. However, the total number who was screened by all of the child-serving agencies who did not meet the Program's eligibility criteria is unknown.
- Data Collected between July 1, 2006, and December 31, 2006, on 6,183 children/adolescents through the web-based NC-TOPPS showed most of the children/adolescents lived with their parents or guardians (68%); 22% were in residential programs.

<u>Living Situation</u>	
Parent or Guardian Home	68%
Residential Program	22%
Institution/facility	3%
Temporary Housing	1%
Other	5 %

- The number of children/adolescents entering DSS custody for the first time increased slightly from 6,008 in SFY 2005, to 6,085 in SFY 2006. However, the percentage of children/adolescents ever placed in non-family settings declined from 21 percent in SFY 2005, to 16 percent in SFY 2006.

(4) *Average length of stay in residential treatment, transition and return to home.*

Average Length of Stay in Residential Treatment SFY 2005- 2006		
Type of Service	Number of children/ adolescents served	Average Length of Stay (Days) per person
Level II	2,806	2,842
Level III	3,874	148.7
Level IV	177	130.6
Psych. Residential Treatment (PRTF)	316	136.5
Inpatient hospital	3,375	16.3
Total	10,548	3,274.1

- Each of these services has specific medical necessity requirements so that a child's/adolescent's needs are matched to the correct type of residential setting and goals are specified in the child's/adolescent's Person Centered Plan. When a child/adolescent has achieved his/her goals related to the residential service that is being provided, the child/adolescent may transition back to his/her family or to a less intensive level of residential care if that is needed. A utilization review process is in place to monitor progress toward goals and to determine whether the child/adolescent is in need of continuing to receive service at the current level of residential service or whether services of less or greater intensity are indicated to meet the child's/adolescent's current needs.
- (5) *The number of children diverted from institutions or other out of home placements such as training schools (Youth Development Centers) and State psychiatric hospitals and a description of the services provided.*
- Initiatives like the MAJORS program provide evaluation, training, technical assistance and diversion from court involvement to substance-related use juvenile justice involved children/ adolescents.
 - With the dismissal of the Willie M Lawsuit, and the integration of children/adolescents into a more comprehensive array of MH/DD/SAS, the LMEs no longer tracked diversions of children/adolescents who were part of the Willie M. class.
- (6) *Recommendation on other areas of the Program that need to be improved.*
- Children/adolescents who are at risk for co-occurring service needs such as those experiencing fetal alcohol syndrome spectrum disorder, those who have been exposed to community or domestic violence and other trauma will need a different level of clinically trained professionals. These professionals will be skilled in providing Trauma Based Cognitive-Behavioral Therapy, a Best Practice model of treatment. Recommendations addressing trauma needs are contained in three different reports in SFY 2006: a legislative study regarding domestic violence and mental health/substance-related use treatment needs, an Institute of Medicine report on prevention of child maltreatment and a school mental health strategic plan through the NC Collaborative for Children, Youth and Families.

- Building provider capacity as a whole continues to be a focus, especially in assessment, diagnosis, and implementation of evidenced based practices and services in communities.
- Cross-agency training and education has increased in the past two years, especially between DSS and DMH/DD/SAS and also with DPI and DHHS/DMH/DD/SAS and DPH. This is a continued and expanding need to help staff from various child/adolescent-serving agencies to better understand each agency's role in the service delivery process, individual mandates, and potential barriers to service coordination for each agency.
- Private providers, children/adolescents and families continue to need incentives for on-going training opportunities to ensure the System of Care approach and community collaboration is being successfully integrated into all level of supports and services. Training should particularly address and provide guidance in utilizing CTSP funding in innovative, non-traditional ways as well as the more traditional ways of doing business.
- Particular emphasis is and must be on assuring all families and child/adolescent serving providers receive training on all phases of "Implementing Child and Family Teams from a Family's Perspective" (team building, facilitation, supervision and evaluation) as a coordinated cross-agency funded effort.
- In addition, concerted effort must be given to assure that all families and stakeholders receive training on choosing a provider, informed consent and decision-making.